Trust Pharmacy Team

CCG Link Incentive Scheme

Audit Protocols

Version	Date	Author	Rationale
1.0	05/01/2021	Eleanor Barnes	Document creation
2.0	21/02/2021	Eleanor Barnes	Addition of new topics – emollients and fire safety
3.0	11/10/2021	Eleanor Barnes	Addition of new topics – DOAC doses, Methotrexate and NSAIDs; GI protection, and Vitamin B Co Strong
4.0	01/12/2021	Eleanor Barnes	Addition of new topics – buprenorphine patches
5.0	17/04/2022	Eleanor Barnes	Addition of new topics – duplicate inhaler ingredients, co-proxamol, montelukast dosing, valproate pregnancy prevention programme
6.0	04/08/2022	Eleanor Barnes	Addition of new topic – safety pen needles
7.0	07/09/2022	Eleanor Barnes	Addition of new topic – dual antiplatelet therapy

Contents

Aim

The aim of this document is to provide a structure to process workload highlighted by the CCG Link Incentive Scheme (LIS).

Scope

For all registered pharmacy technicians working in the Trust Pharmacy Team.

Background

Review

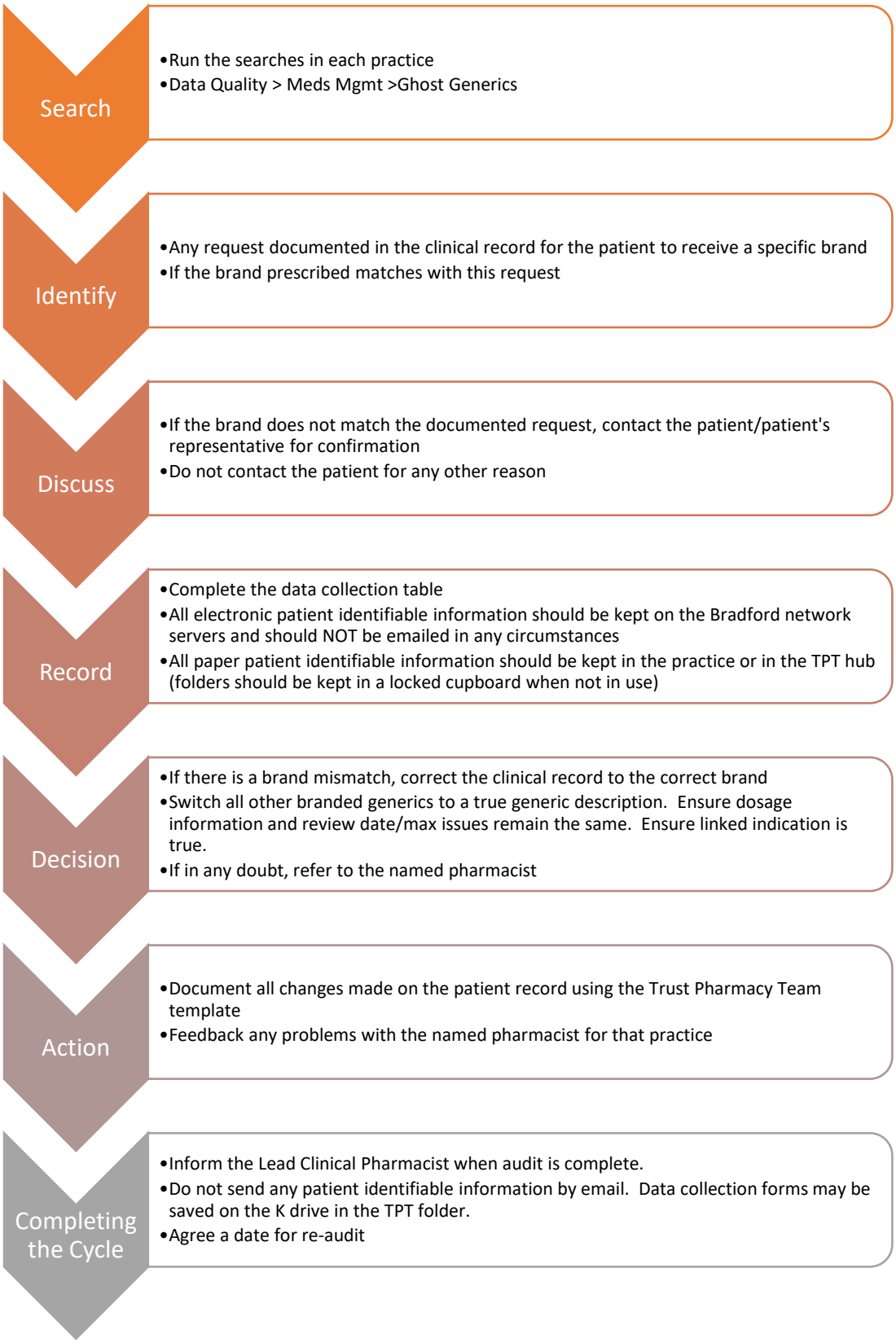
September 2024

References

1.

Ghost Generics

If in any doubt at any stage, refer to the named pharmacist, or GP (in this order).



Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

Patient Name	DOB	Age	Ghost Generic	Reason to keep as branded generic?	Switched (Y/N)	Comments

Summary

Ghost Generics

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

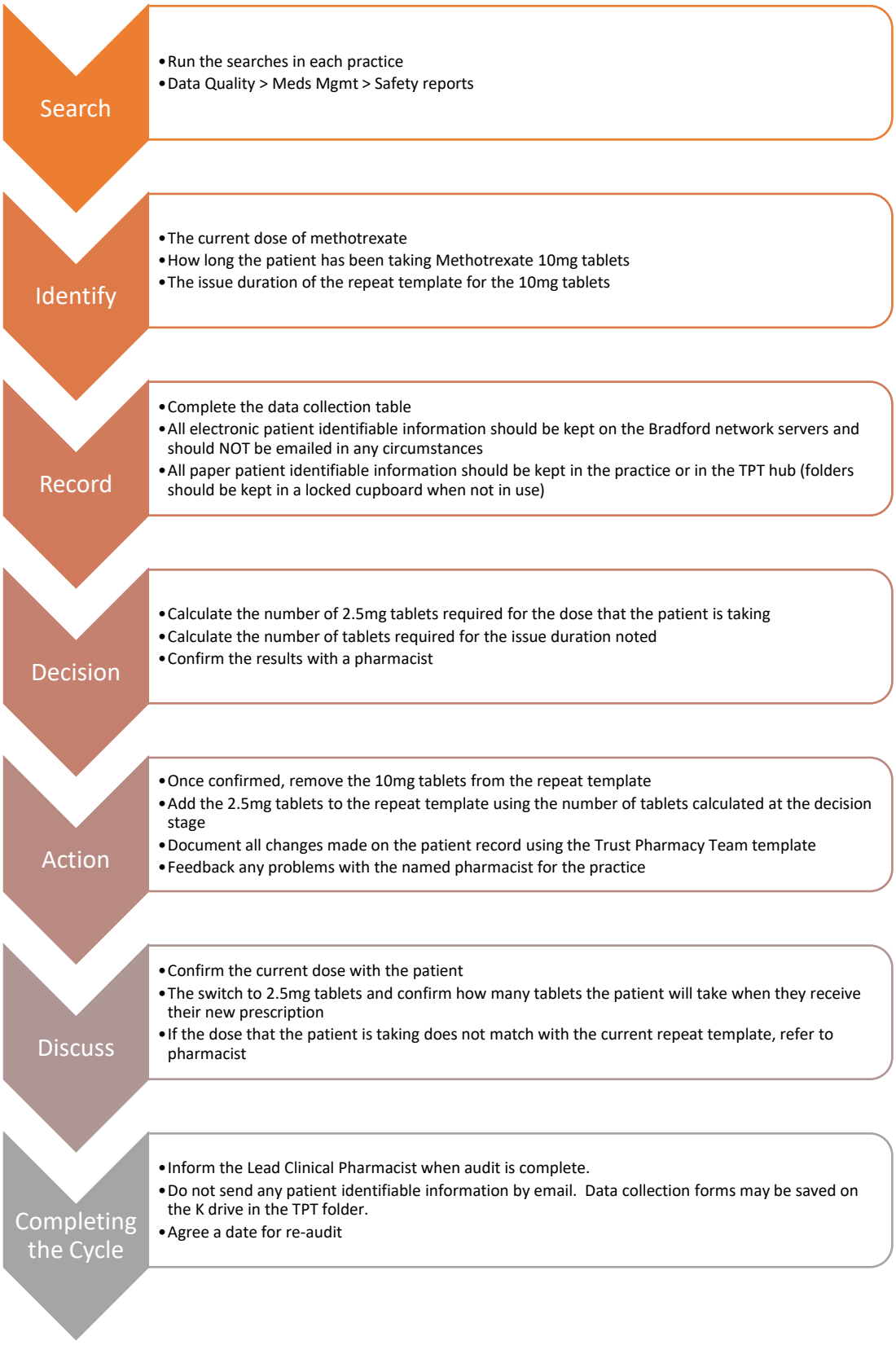
Date Audit Completed .....

Re-audit date .....

Information sent to CCG and LCP ☐

Methotrexate 10mg tablets

If in any doubt at any stage, refer to the named pharmacist, or GP (in this order).



Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

A	B	C	D	E	F	G	H	I	J	K
Patient Name	DOB	Age	Current dose of methotrexate	Issue duration of 10mg tablets	Number of 2.5mg tablets required for WEEKLY dose	Number of 2.5mg tablets required for issue duration (column E multiplied by column F)	Dose confirmed with patient (Y/N)	Patient counselled on 2.5mg tablets (Y/N)	Switched (Y/N)	Comments

Summary

Methotrexate 10mg tablets

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

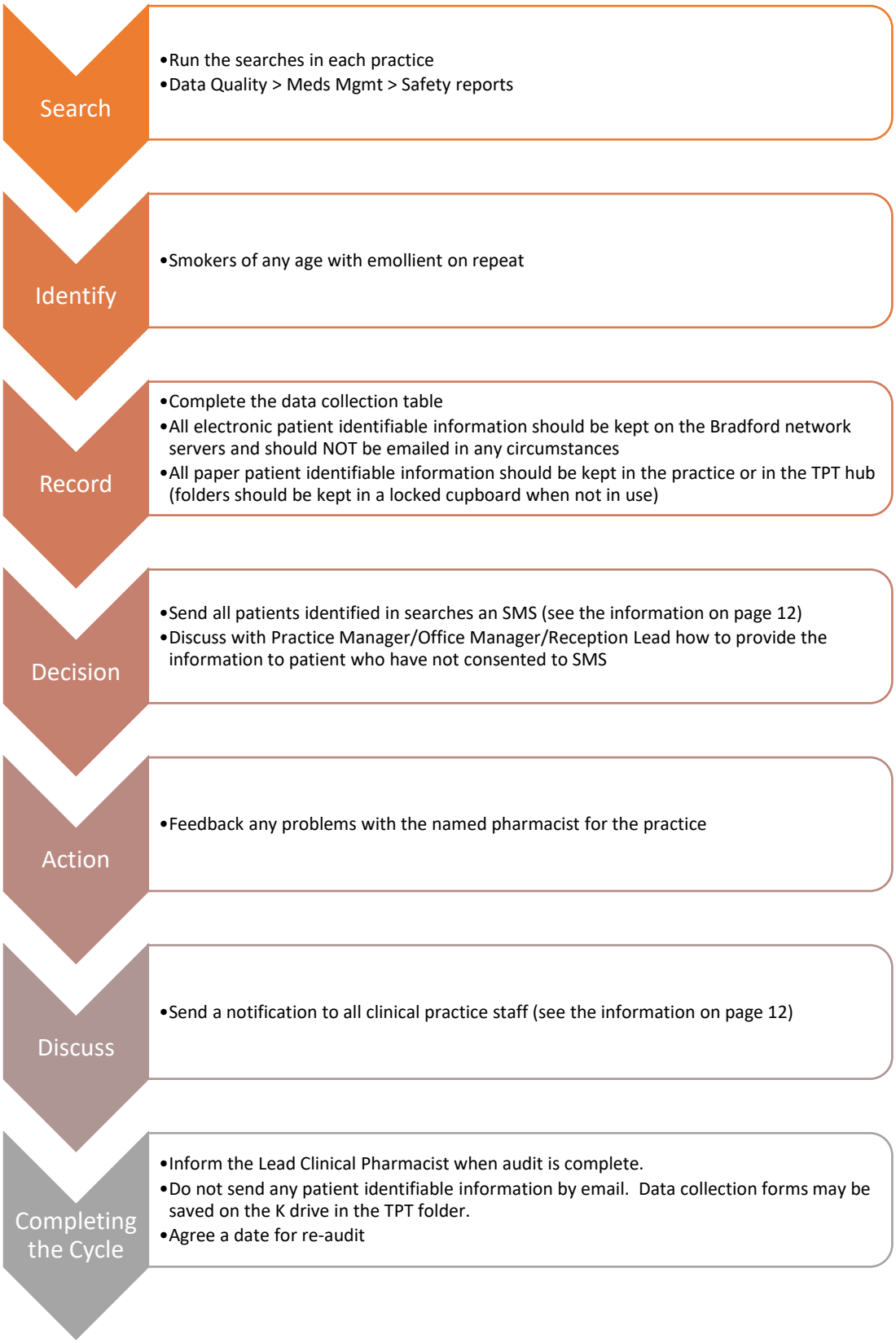
Date Audit Completed .....

Re-audit date .....

Information sent to CCG and LCP ☐

Emollients and Fire Safety

If in any doubt at any stage, refer to the named pharmacist, or GP (in this order).



Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

A	B	C	D	E	F	G
Patient Name	DOB	Age	Information sent by SMS (Y/N)	Information sent by letter (Y/N)	Information sent by another method (Y/N)	Comments

Example SMS

There have been tragic cases across Bradford where some patients have suffered severe burns caused by fabrics covered with creams/ointments for eczema & other skin conditions. Visit the website https://www.gov.uk/guidance/safe-use-of-emollient-skin-creams-to-treat-dry-skin-conditions to reduce your risk

Example Notification

Dear colleague

Those who have worked in Bradford for a few years will be aware that Bradford and Calderdale have sadly had a number of fatalities due to severe burns caused by emollient saturated fabrics. The CCG medicines management team has asked us to share the details with all clinicians about the new national emollient fire risk campaign. The details can be found here.

We are contacting all patients with emollients on repeat who are smokers and inviting them to visit this website to find out more information on reducing their risk. If you wish to know more, please do get in touch.

Many thanks

Summary

Emollients and Fire Safety

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

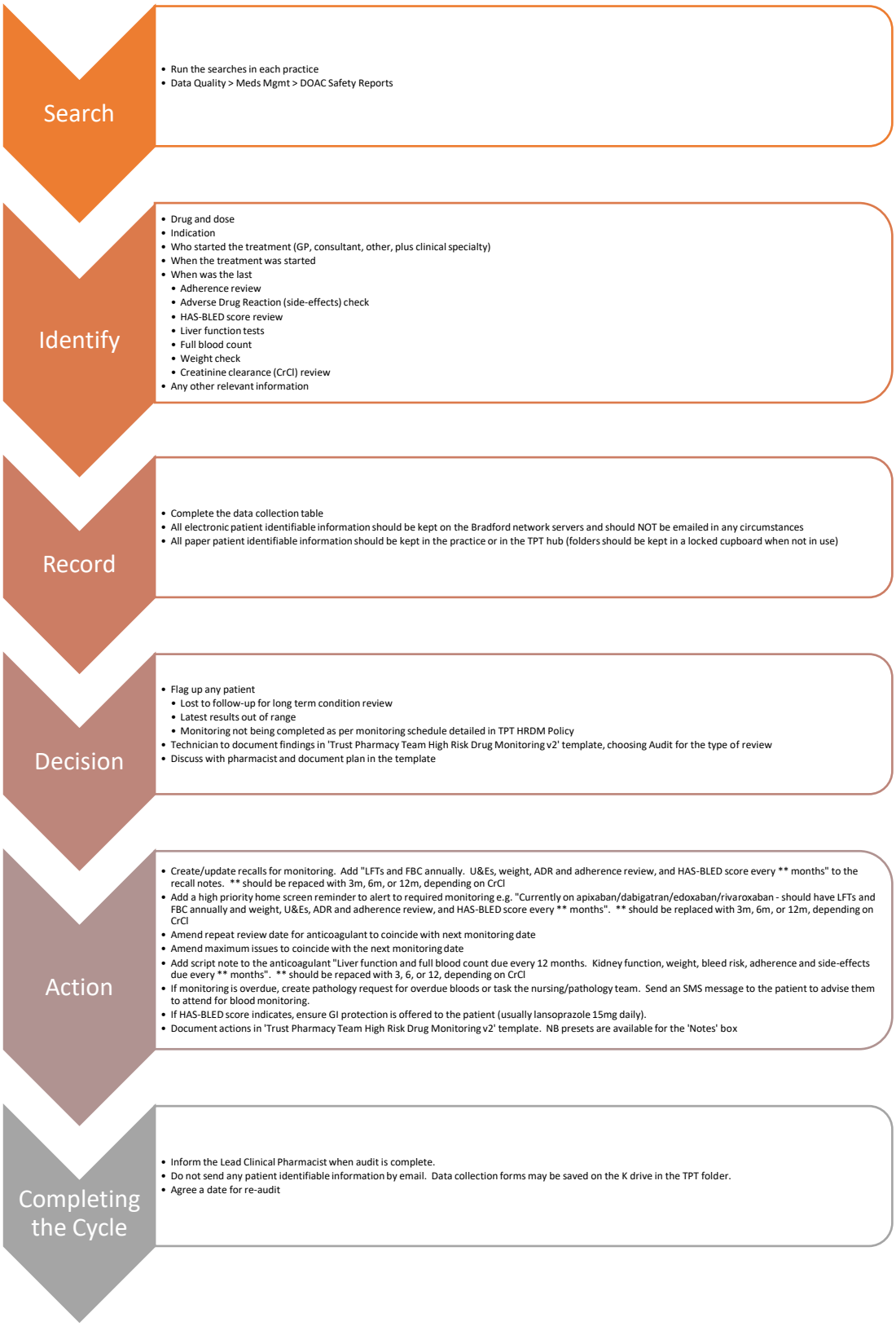
Date Audit Completed .....

Re-audit date .....

Information sent to CCG and LCP ☐

DOAC Dose Reconciliation

If in <u>any</u> doubt at <u>any</u> stage, refer to the named pharmacist, or GP (in this order).



Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

A	B	C	D	E	F	G	H	I	J	K	L	M
Patient Name	DOB	Age	Drug and dose	Indication	Initiating specialty	Start date	Date of last adherence review	Date of last ADR check	Date of last HAS-BLED score review	HAS-BLED score	Date of last LFTs	Date of last FBC
							With every test, at least annually	With every test, at least annually	With every test, at least annually		Annually	Annually

N	O	P	Q	R	S	T
Date of last weight check	Last creatinine clearance (ml/min)? Date checked?	Frequency that monitoring should have occurred based on CrCl?	Have tests been monitored at the correct frequency? If not, which tests have not been correctly monitored?	Have reviews been done at the correct frequency? If not, which reviews have not been correctly monitored?	Does the HAS-BLED score indicate gastro-protection? Is the patient currently taking GI protection? Drug and dose?	GI protection offered? Accepted or refused?
With every test, at least annually		If prev CrCl: 15-29ml/min – 3m 30-59ml/min – 6m >60ml/min - 12m	Consider LFTs, FBC, U&Es (to include serum creatinine), and weight.	Consider HAS-BLED, adherence, and ADRs	Consider adherence of GI protection. Possibly on repeat but not being taken. Check date of last issue.	

Summary

DOAC Dose Reconciliation

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

Date Audit Completed .....

Re-audit date .....

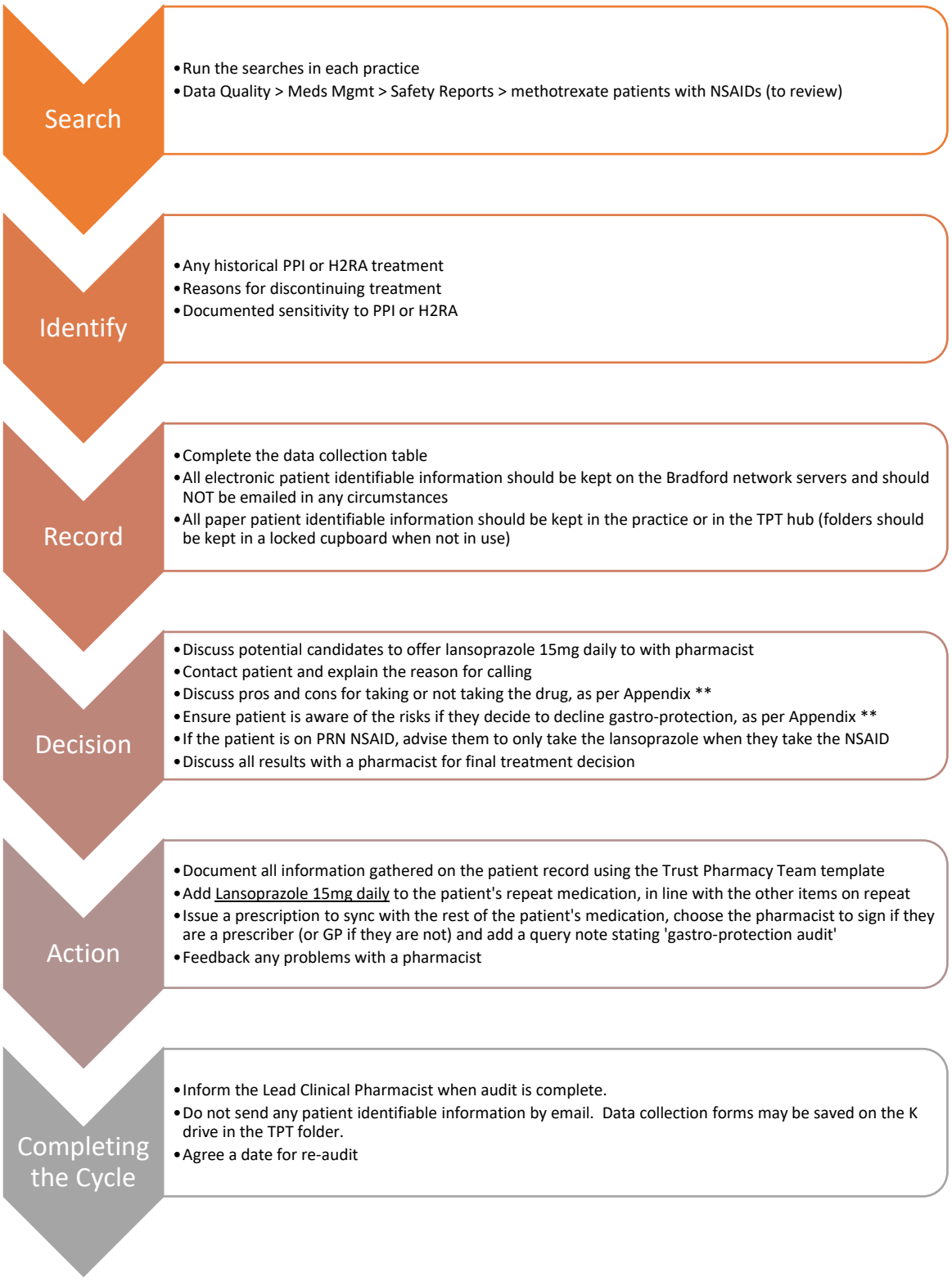
Information sent to CCG and LCP ☐

1	Number of patients identified on searches	
2	Number of patients reviewed	
3	Number of patients on incorrect dose for the indication/age/weight/renal function etc.	
4	Number of patients with incorrect dose that have been switched to correct dose	
5	Explanation of any difference between numbers for points 3 and 4	

Methotrexate and NSAIDs; GI Protection

If in any doubt at any stage, refer to the named pharmacist, senior pharmacist, or GP (in this order).

Interaction Between Low-Dose Methotrexate and Nonsteroidal Anti-inflammatory Drugs, Penicillins, and Proton Pump Inhibitors https://pubmed.ncbi.nlm.nih.gov/27701081/



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Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

Patient Name	Age	GI risk indicator?	History of GI protection?	Reason for stopping?	Sensitivity to GI protection?	Recommendation	Information given to pt?	Concerns raised by pt?	Confirmation of tx by pharmacist (Give detail of tx)	Added to rpt and rx issued?	Comments

Patient Information

Information about taking gastro-protective medicines

Pros	Cons
Lowers risk of bleeding in the stomach which can cause an emergency admission to hospital	At higher doses, PPIs can make patients more at risk of C. difficile infection. We are using lower doses which are not connected to this.
Reduces side effects such as burning in the back of the throat or in the sternum, a bad taste in the mouth.	PPIs can increase the risk of fractures (particularly when used at high doses for more than 1y in the elderly). We will choose an H2RA if the fracture risk is high.
Lots of evidence around safety at the doses we are suggesting and is well tolerated by most patients.	GI protective medicines may mask the signs of gastric cancer. All patients must report unusual developments, including • Problems swallowing, • Feeling or being sick, • Feeling full very quickly when eating • Loss of appetite • Losing weight without trying to • A lump at the top of the tummy • Pain at the top of the tummy • Feeling tired or having no energy

Information about declining gastro-protective medicines

Pros	Cons
No change to therapy, less confusion. However, if patient must continue GI risky meds then at higher risk of GI bleeding.	Remains at higher risk of GI bleeding which could lead to an emergency hospital admission.
No adverse effects to new medication. However, if patient must continue GI risky meds then at higher risk of GI bleeding.	

Summary

Methotrexate and NSAIDs; GI Protection

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

Date Audit Completed .....

Re-audit date .....

Information sent to CCG and LCP ☐

1	Number of patients identified in searches	
2	Number of patients reviewed	
3	Number of patients requiring intervention around type or dose of gastroprotection	
4	Number of patients with successful intervention	
5	Explanation of any difference between numbers for points 3 and 4	

Vitamin B preparations

Aim

The aim of this audit is to provide a structure for ensuring that all prescribing of Vitamin B Complex is in line with NICE guidance.

Background

In chronic alcohol consumption, thiamine deficiency is a result of poor nutrition, decreased absorption, and impaired thiamine use in cells.[1] Thiamine deficiency can interfere with brain cellular functions, leading to conditions such as Wernicke–Korsakoff syndrome.[1]

Thiamine with vitamin B compound or vitamin B compound strong were historically prescribed in the UK. Vitamin B compound and vitamin B compound strong are often prescribed three times a day. The tablet burden and dosing schedule are inconvenient for patients and wasteful if not indicated.

In its clinical guideline 'Alcohol-use Disorders: diagnosis and management of physical complications', NICE recommends prescribing thiamine to people at high risk of developing or with suspected, Wernicke's encephalopathy. It does not mention the prescribing of vitamin B.[2]

The prescribing of vitamin B compound or vitamin B compound strong tablets should continue for patients under the care of the renal unit.

Thiamine

Thiamine deficiency is common in alcoholics because of poor diet and gastritis which affects absorption. Thiamine is also a coenzyme used in alcohol metabolism.[3] Deficiency can cause Wernicke's encephalopathy, which if left untreated, can lead to Korsakoff's syndrome.[3]

Parenteral high-potency B complex vitamins (Pabrinex®) may be needed if malnourished or have decompensated liver disease.[2]

If the patient is healthy and well-nourished, and alcohol dependence is uncomplicated, then an alternative is oral thiamine at a minimum dose of 300 mg per day during detoxification (e.g. 100mg TDS).[3]

For maintenance prescribe thiamine 50mg daily.[3]

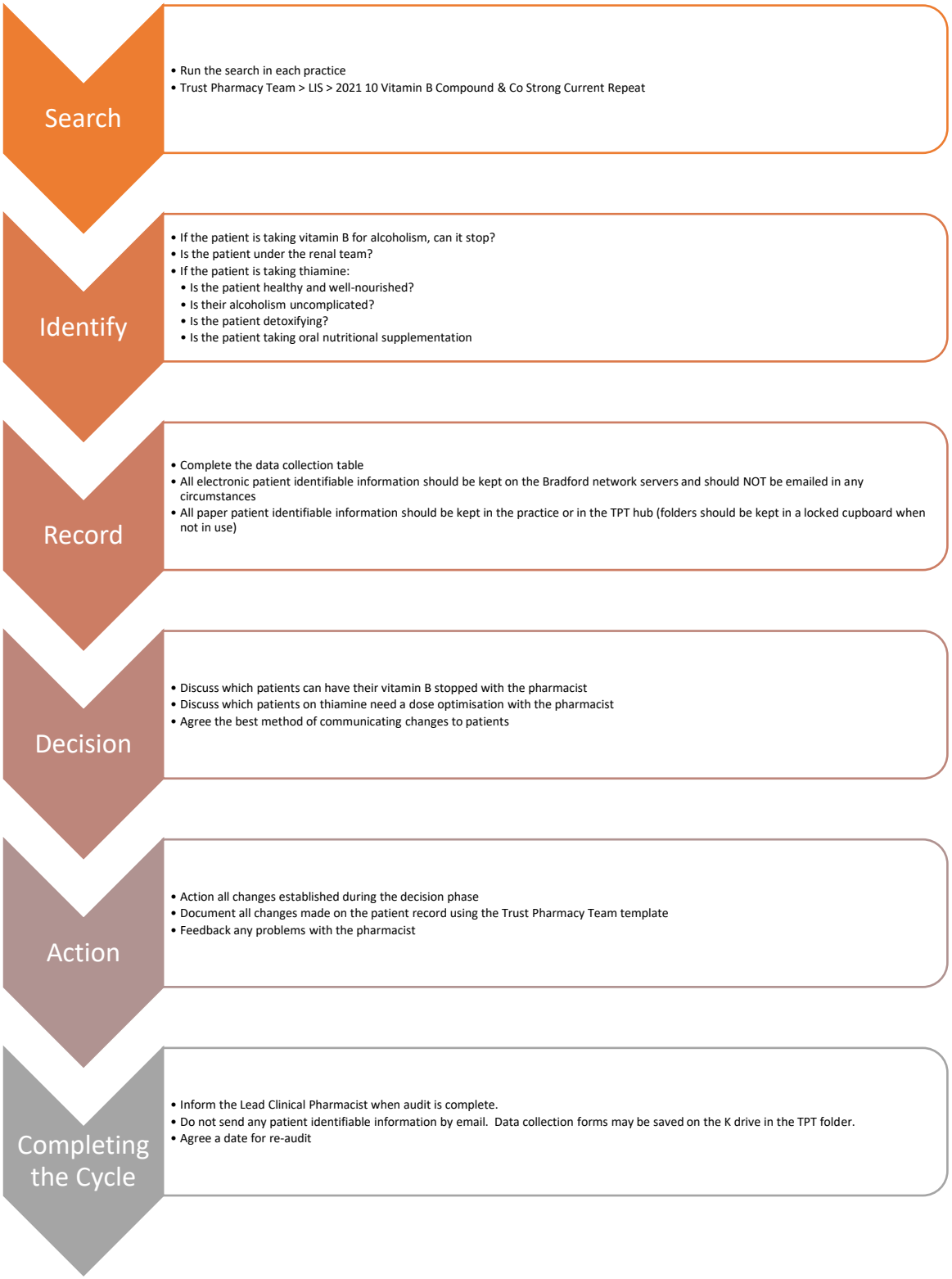
References

1. MARTIN P.R. et al (2003). *The Role of Thiamine Deficiency in Alcoholic Brain Disease*. Alcohol Research and Health. 27(2): pp. 134-42. Accessed on 20th July 2020. Available from https://pubs.niaaa.nih.gov/publications/arh27-2/134-142.htm
2. NICE (2017) *Alcohol-use disorders: diagnosis and management of physical complications. CG100.* National Institute for Health and Clinical Excellence. Accessed on 20th July 2020. Available from https://www.nice.org.uk/guidance/cg100
3. NICE (2018). *Alcohol – problem drinking.* Clinical Knowledge Summaries. Accessed on 20th July 2020. Available from https://cks.nice.org.uk/alcohol-problem-drinking

Process

If in any doubt at any stage, refer to the named pharmacist, senior pharmacist, or GP (in this order).

Any patient under the care of the renal team should be excluded from this audit.



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Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

Patient Name	DOB	Age	On Vit B co or co strong	For alcoholism (Y/N)	Under renal unit (Y/N)	? stop	On thiamine Y/N	On thiamine 200–300mg/day (in divided doses) if undergoing alcohol withdrawal Y/N	On 50mg od if maintenance Y/N	On thiamine needs dose altering	Comments	Cost savings

Letter for patients on vitamin B Co or Co Strong for alcoholism

Letterhead

Our local NHS has recommended that we review the prescribing of **vitamin B co / co strong** as there has been recent new guidance from the National Institute for Care and Health Excellence (NICE).

NICE have reviewed the evidence and found that **vitamin B co / co strong** is not likely to be beneficial and so now do not recommend it as treatment. We would like to therefore suggest that we stop it now.

When you next collect your repeat prescription you will see that **vitamin B co / co strong** is not now on your medication list.

If you have any queries about this change, please do not hesitate to contact the surgery,

Yours sincerely

Letter for patients on thiamine for alcoholism needing a dose change

Letterhead

There have been some new guidelines on doses of thiamine for your condition. As we want to ensure you are receiving the best, most evidence-based treatment, we would like to now change the dose of your thiamine. When you next get your repeat prescription, you will see that you are now prescribed:

Thiamine 50mg take one each day

If you have any queries about this change, please do not hesitate to contact the surgery,

Yours sincerely

Summary

Vitamin B Preparations

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

Date Audit Completed .....

Re-audit date .....

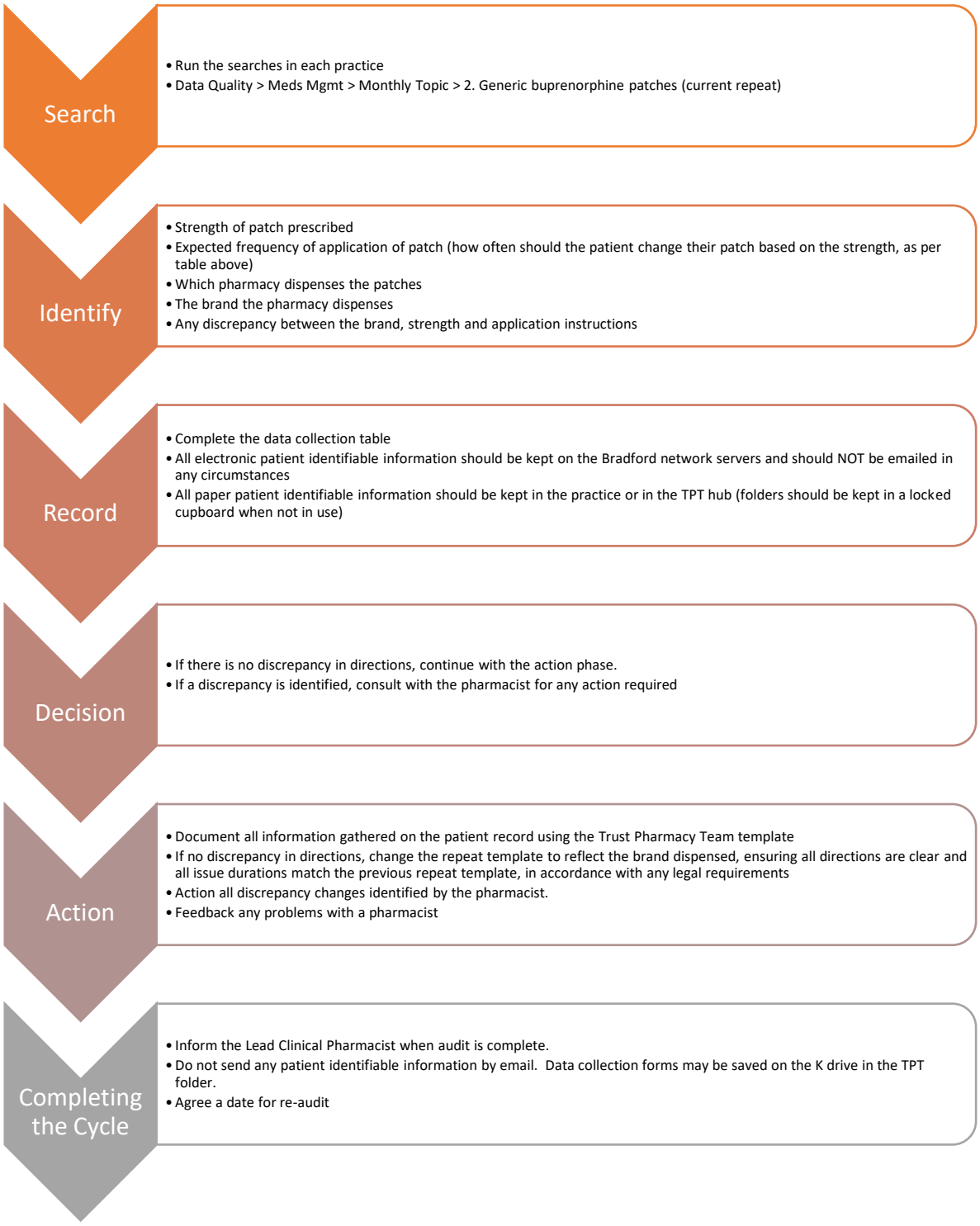
Information sent to CCG and LCP ☐

1	Number identified on vitamin b co and vitamin b co strong	
2	Number on vitamin b co and vitamin b co strong for kidney disease	
3	Number vitamin b co and vitamin b co strong stopped	
4	Explanation of any difference between numbers in points 1 and 3	
	Number identified on thiamine	
	Number on thiamine needing dose altering	
	Annual savings made	

Generic buprenorphine patches

If in any doubt at any stage, refer to the named pharmacist, senior pharmacist, or GP (in this order).

Brand	Strengths Available (release rate per hour)	Duration of Action
BuTrans, Sevodyne, Butec, Reletrans, Bupramyl, Panitaz,	5mcg, 10mcg, 20mcg	7 days
TransTec, Bupease, Relevtec, Buplast,	35mcg, 52.5mcg, 70mcg	4 days
Hapoctasin, Prenotrix,	35mcg, 52.5mcg, 70mcg	3 days



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Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

Patient Name	Age	Strength of burprenorphine patch prescribed	Expected application frequency	Application frequency on directions	Discrepancy between expected and actual application frequency? (Yes/No)	Nominated pharmacy	Brand dispensed	Rpt updated? (Yes/No)	Comments

Summary

Generic buprenorphine patches

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

Date Audit Completed .....

Re-audit date .....

Information sent to CCG and LCP ☐

1	Number of patients identified for review	
2	Number of patients switched to correct branded product	
3	Reason for any discrepancy between 1 and 2	

Inhalers with duplicate ingredients on repeat

Aim

The aim of this audit is to provide a structure for ensuring that all prescribing of inhalers with more than one active ingredient is done so in a safe manner, avoiding any duplication of therapy.

Background

References

1.

Process

If in any doubt at any stage, refer to the named pharmacist, senior pharmacist, or GP (in this order).

Any patient under the care of the renal team should be excluded from this audit.

Search

- Run the search in each practice (NOT Ashwell, Hollyns, Leylands, or Manor)
- Data Quality > Meds Mgmt > Safety reports > 20. More than one duplicate inhaler ingredient on repeat (combines all 3 searches)

Identify

- Inhalers with duplicate ingredients
- Who started the newest inhaler and their role
- When the newest inhaler was started
- Why a duplication has occurred (if easily identifiable e.g., poor reconciliation, misunderstanding of ingredients)

Record

- Complete the data collection table
- All electronic patient identifiable information should be kept on the Bradford network servers and should NOT be emailed in any circumstances
- All paper patient identifiable information should be kept in the practice or in the TPT hub (folders should be kept in a locked cupboard when not in use)

Decision

- Discuss which inhaler to continue with the pharmacist
- Confirm the brand of the inhaler and its active ingredients
- Agree the best method of communicating changes to patients

Action

- Action all changes established during the decision phase
- Document all changes made on the patient record using the Trust Pharmacy Team template
- Feedback any problems with the pharmacist

Completing the Cycle

- Inform the Lead Clinical Pharmacist when audit is complete.
- Do not send any patient identifiable information by email. Data collection forms may be saved on the K drive in the TPT folder.
- Agree a date for re-audit

Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

A	B	C	D	E	F	G	H	I	J
Patient Name	DOB	Age	Inhaler 1	Inhaler 2	Inhaler 3	Date duplication occurred	Name of individual who duplicated therapy	Role of individual who duplicated therapy	Reason for duplication

K	L	M	N	O
Inhaler to continue (name of inhaler)	Branded prescribing?	Ingredients added to script notes?	Patient informed (Yes/No)	Cost savings

SMS for patients with duplicate inhalers

Dear <forename>, you have been using 2 inhalers with the same ingredients. The inhaler you should continue to use is <NAME>. Please stop using your <NAME> and return it to your pharmacy to destroy. If you experience a decline in your symptoms, contact reception to book a review with the nurse.

Summary

Inhalers with duplicate ingredients on repeat

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

Date Audit Completed .....

Re-audit date .....

Information sent to CCG and LCP ☐

1	Number identified on duplicate ingredients	
2	Number of patients reviewed	
3	Number of patients requiring “housekeeping” removal of repeat item	
4	Number of patients using or ordering inhalers incorrectly that required active intervention	
5	Number of patients on correct treatment	

Co-proxamol

Aim

The aim of this audit is to provide a structure for ensuring that all prescribing of co-proxamol is minimal and

Background

Prescribing of co-proxamol has long been discouraged and prescribing is not recommended. We would like to renew our efforts to stop prescribing in existing patients. Bradford currently has one of the highest prescribing rates in the country. The risk of harm from co-proxamol is considerable and well known and prescribers are leaving themselves open to medico-legal action should there be any patient harm as a result. We would like the pharmacy teams to discuss the risks of ongoing prescribing with the individual prescribers who are still issuing prescriptions to patients.

Whilst some patients may find some relief from co-proxamol still, the reducing numbers of patients continues to push up the cost of each prescription with the average cost of one prescription item in Nov 21 being £473 compared to £175 per item in Nov 2018. We estimate that this will continue to rise.

Not all practices have patients remaining on co-proxamol. Those with continued prescribing are detailed in recent CCG communication (see embedded file below). Noting the discrepancy between some of these item costs it may be pertinent to check which supplier the dispensing pharmacy is using. As co-proxamol is a specials order medicine costs can vary widely. Some pharmacies may be happy to consider an alternative supplier and these conversations are encouraged where costs are excessively high.

Further information to support your conversations can be found here:

https://www.gov.uk/drug-safety-update/-dextro-propoxyphene-new-studies-confirm-cardiac-risks

https://www.gov.uk/drug-safety-update/co-proxamol-withdrawal-reminder-to-prescribers

PCN Link Pharmacy Scheme - Monthly T

References

1.

Process

If in any doubt at any stage, refer to the named pharmacist, senior pharmacist, or GP (in this order).

Identify

- Identify each practice affected as per Appendix 1 in PCN LInk Pharmacy Scheme - Monthly Topic March 2022

Action

- Send a notification to all prescribers in the practice using the text below (under 'Communication')
- Copy in the named TPT staff and the Lead Clinical Pharmacist for info
- Feedback any problems with the pharmacist

Completing the Cycle

- Inform the Lead Clinical Pharmacist when audit is complete.
- Inform the CCG when all actions have been completed by emailing meds.opt@nhs.net

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Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

Patient Name	DOB	Age										

Practice Communication

Subject line: Co-proxamol medico-legal implications

Dear colleague

Please see info below from the CCG:

Prescribing of co-proxamol has long been discouraged and prescribing is not recommended. We would like to renew our efforts to stop prescribing in existing patients. Bradford currently has one of the highest prescribing rates in the country. The risk of harm from co-proxamol is considerable and well known and prescribers are leaving themselves open to medico-legal action should there be any patient harm as a result. We would like the pharmacy teams to discuss the risks of ongoing prescribing with the individual prescribers who are still issuing prescriptions to patients.

Whilst some patients may find some relief from co-proxamol still, the reducing numbers of patients continues to push up the cost of each prescription with the average cost of one prescription item in Nov 21 being £473 compared to £175 per item in Nov 2018. We estimate that this will continue to rise.

If you wish to discuss your current prescribing of co-proxamol and patients affected, please feel free to discuss with <Named TPT pharmacist/technician>.

Many thanks

Trust Pharmacy Team

Summary

Co-proxamol

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

Date Audit Completed .....

Re-audit date .....

Information sent to CCG and LCP ☐

1	Please confirm that each prescriber currently signing co-proxamol prescriptions is aware of the medico-legal implications of doing so, and of the cost of treatment. Ashcroft (Yes/No) Bowling Highfield (Yes/No) Farrow (Yes/No) Idle (Yes/No) Low Moor (Yes/No) Moorside (Yes/No) Rockwell and Wrose (Yes/No) Rooley Lane (Yes/No) Saltaire (Yes/No) Tong (Yes/No)

Montelukast dosing

Aim

The aim of this audit is to provide a structure for ensuring that all prescribing of Montelukast is in line with recommendations in the BNFc and BNF, according to age and weight.

Prescriptions for montelukast 4mg and 5mg should be checked to ensure that they are still appropriate. This should include a check of dose appropriateness but also where necessary this may prompt a review of whether the montelukast has been effective and could be considered for stopping.

The 4mg dose is licensed for patients aged 2 to 5, the 5mg dose for 6 to 14 year olds, and the 10mg dose for aged 15 and older.

Background

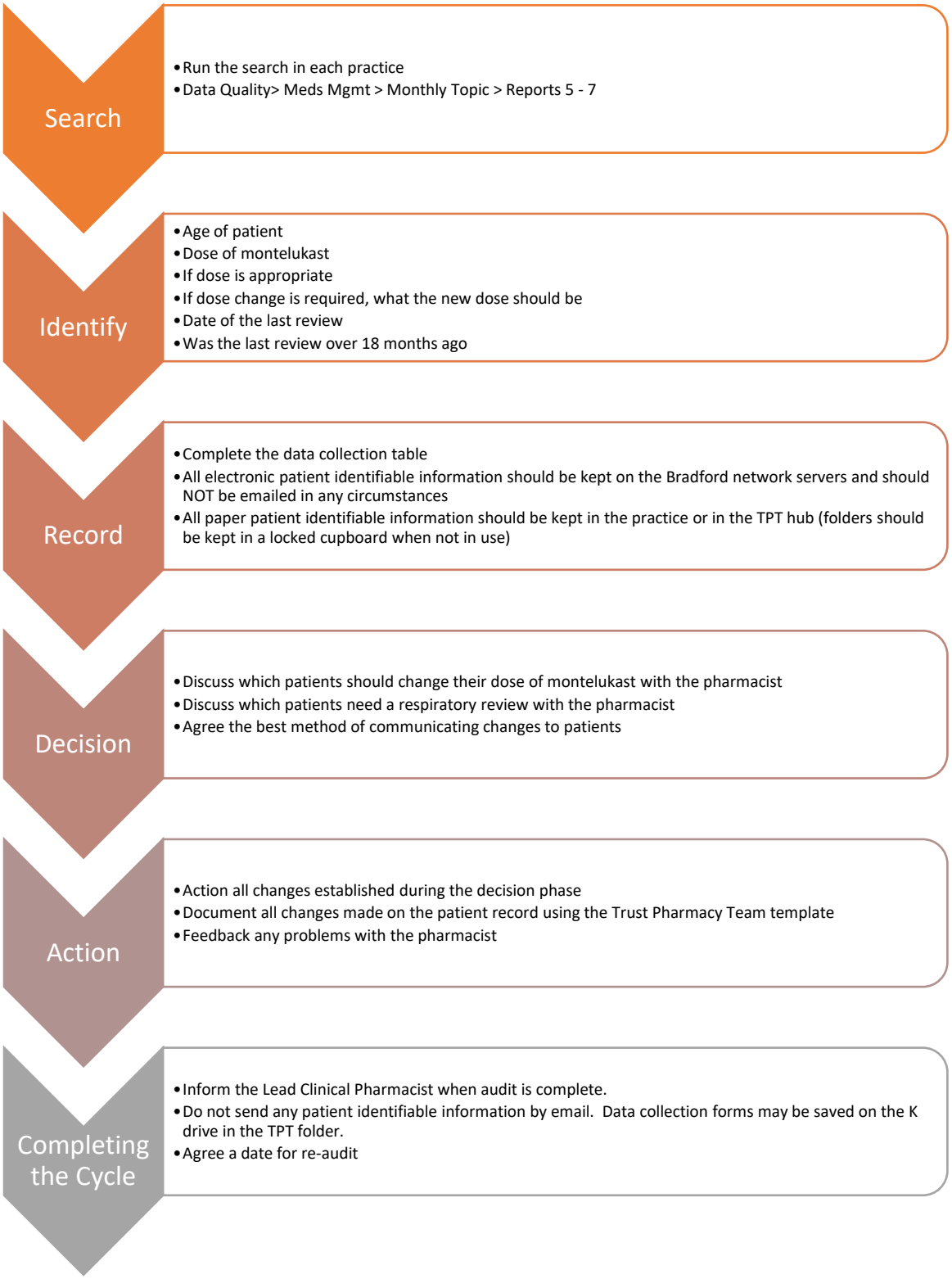
References

1.

2.

Process

If in any doubt at any stage, refer to the named pharmacist, senior pharmacist, or GP (in this order).



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Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

Patient Name	DOB	Age	Current dose of montelukast	Dose appropriate (yes/no)	If inappropriate, what should the new dose be?	When was the last respiratory review	Was this 18 months ago or longer?	Dose changed on repeat (yes/no)?	Patient informed (yes/no)?	Referred for review (yes/no)?

If dose change is indicated

Dear <forename>, now that you are <age>, your dose of montelukast needs to go up. You should now take <dose>. We have changed your repeat list and issued a new prescription. Please start taking the new dose when you receive it. If you have any old tablets left, take these to the pharmacy to destroy.

If review is required

Following a review of your medication, you need an appointment with the nurse for a review. Please make an appointment before your next prescription is due. Thank you, Pharmacy Team, <practice>

Summary

Montelukast dosing

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

Date Audit Completed .....

Re-audit date .....

Information sent to CCG and LCP ☐

1	Number of patients identified on searches	
2	Number of patients reviewed	
3	Number of patients requiring review or dose change	
4	Number of patients on correct dose	
5	Explanation of any differences	

Sodium Valproate Pregnancy Prevention Programme (PPP)

Aim

Following the introduction of the sodium valproate PPP in 2018, all practices were asked to ensure that patients had an Annual Risk Acknowledgement Form completed by the specialist.

All practices should revisit patients of childbearing age on valproate to ensure there is an in-date agreement form, or that the patient is permanently exempt (hysterectomy etc).

If patients are found not to have had a consultant review, this should be arranged. The CCG suggests that practices ask the specialist to place the patient on an annual recall, as recent conversations would suggest that this is not always occurring, and patients are being discharged from specialist services after each review.

Background

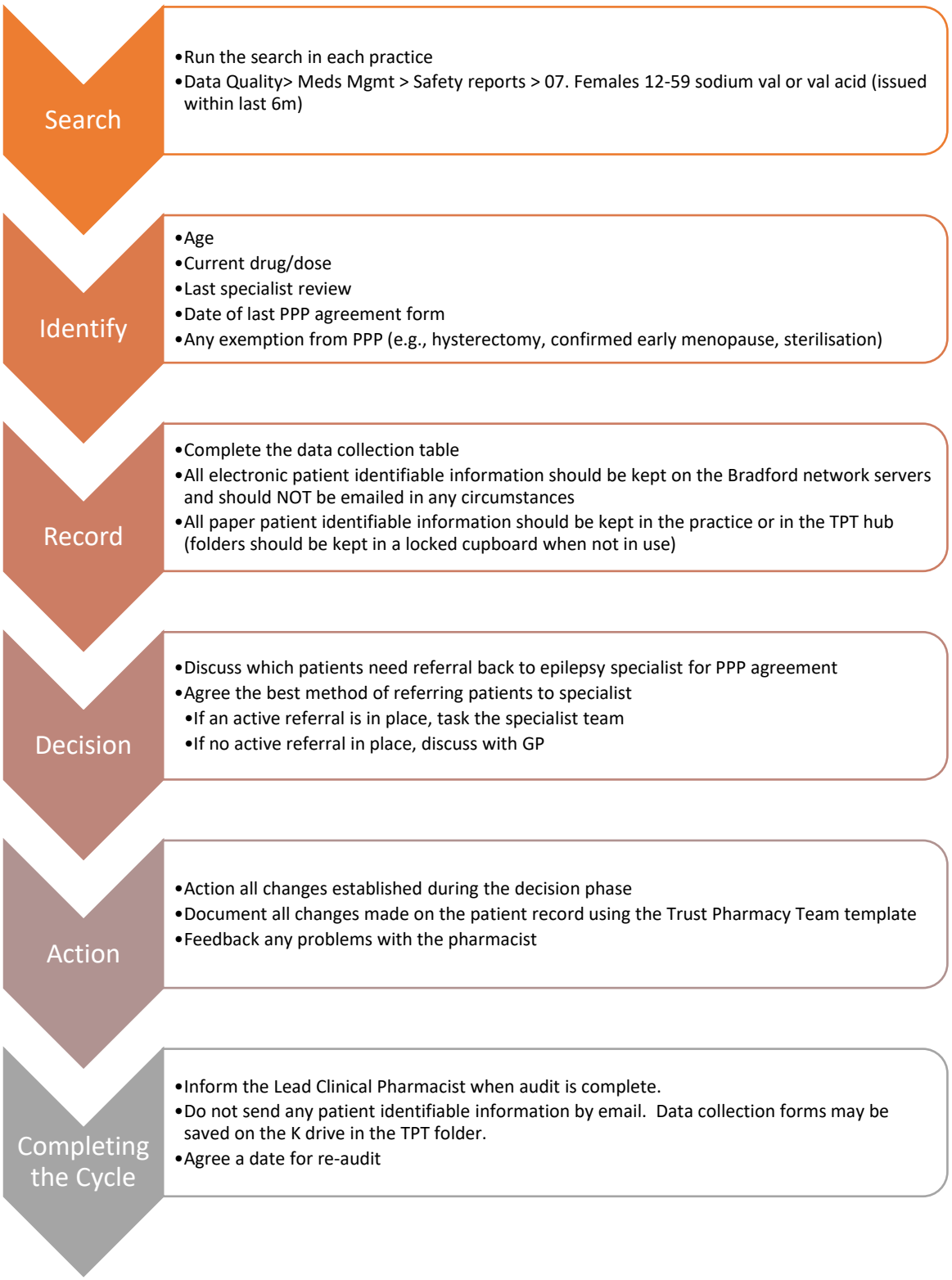
References

1.

2.

Process

If in any doubt at any stage, refer to the named pharmacist, senior pharmacist, or GP (in this order).



Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

Patient Name	DOB	Age	Current drug/dose	Last specialist review	Date of last PPP agreement form	Exemption from PPP?	Task sent to specialist?	Task to GP to refer back to epilepsy team?

Tasks

To request specialist review

Hi

A recent audit has shown this this patient has not had an agreement form documented as part of the valproate pregnancy prevention programme. Please can you action this and send us a copy of the form?

To request referral back to specialist

Hi

This patient is taking valproate and seems to have no exemption from the valproate pregnancy prevention programme. I cannot see an active referral to a specialist team who would usually do this. Would you like to refer them in so this can be actioned please?

Summary

Sodium Valproate Pregnancy Prevention Programme (PPP)

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

Date Audit Completed .....

Re-audit date .....

Information sent to CCG and LCP ☐

1	Number of patients identified on searches	
2	Number of patients reviewed	
3	Number of patients with in-date PPP in place	
4	Number of patients requiring referral to specialist for new Annual risk acknowledgement form	
5	Number of patients exempt (no risk of pregnancy)	

Insulin Pen Safety Needles

Aim

The insulin pen needles formulary was updated and shared in recent months, with a position that safety insulin pen needles (BD Autoshield Duo) should only be prescribed for community nursing teams. Patient's relatives should not require them, and care homes should be providing their own needles as staff PPE.

There are relatively small numbers of patients in many PCNs, so these should be checked for appropriateness of prescribing and stopping if they do not meet the policy requirements.

Background

References

1.

2.

Process

If in any doubt at any stage, refer to the named pharmacist, senior pharmacist, or GP (in this order).

Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

Patient Name	DOB	Current pen needle	Administration method (HCP, carer, self)	If carer administration, is there a risk of blood-borne disease infection	Pen needle switched? (Yes/No)	New pen needle

Summary

Insulin Pen Safety Needles

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

Date Audit Completed .....

Re-audit date .....

Information sent to CCG and LCP ☐

1	Number of patients identified on searches	
2	Number of patients reviewed	
3	Number of patients correctly prescribed safety needles for use by community nursing teams	
4	Number of patients requiring switch to standard needles	
5	Explanation of any difference	

Dual antiplatelet therapy

Background

Aspirin should be offered to all people after a Myocardial Infarction (MI) and continued indefinitely unless they are aspirin intolerant or have an indication for anticoagulation. Depending on the condition, a second antiplatelet, such as ticagrelor, prasugrel or clopidogrel, may be offered in combination with aspirin for a defined period, generally up to 12 months.

There have been many reports of people continuing dual antiplatelet therapy beyond the recommended time limit because of a lack of clarity about the duration of co-prescribing. This can lead to adverse consequences for the person taking the dual antiplatelets. In addition, doses of prasugrel vary according to the age of the person and ticagrelor has different dose regimes depending on the indication.

While dual anti-platelet therapy has benefits in terms of reducing cardiovascular morbidity and mortality, the risk of bleeding increases with increasing length of dual therapy.

Conditions for which dual antiplatelet therapy may be used include:

- Acute coronary syndrome (ACS), medically managed
- Primary coronary intervention (PCI) in ACS
- PCI in people with stable coronary artery disease
- ACS undergoing coronary artery bypass graft (CABG)
- Stroke or transient ischaemic attack (TIA), where clopidogrel alone is unsuitable (aspirin and modified-release dipyridamole is the preferred combination)

Antiplatelet monotherapy is indicated for conditions which include:

- Angina
- ACS (longer than 12 months ago)
- Stroke or TIA
- Peripheral arterial disease (PAD), or multivascular disease

When treatment with an antiplatelet is indicated, a risk assessment of the patient's bleed risk should occur. The HAS-BLED and ORBIT tools have been ratified for use within the NHS as risk assessment tools for patients with atrial fibrillation. No specific tool is recommended by NICE to assess bleeding risk with antiplatelets for those without atrial fibrillation. Pragmatic clinical judgment should be exercised when assessing bleeding risk and when considering the risk:benefit ratio in clinical decision making.

Factors which increase the risk of GI bleed include:

- Age (65 years or older)
- Anaemia (Hb < 11g/L)
- Impaired renal function
- History of GI bleeding
- Hepatic impairment
- Excessive alcohol intake

- Concomitant medication
    - NSAIDs
    - SSRIs/SNRIs
    - Corticosteroids
    - Anticoagulants
    - Other antiplatelets (i.e., more than one antiplatelet)

Further Resources

Real Health Cardiovascular 2020. GP Infosheet – antithrombotics and bleeding risk https://www.qmul.ac.uk/blizard/ceg/media/blizard/real-health/files/RH-CVD---GP-Infosheet---Antiplatelets,-anticoagulants-and-bleeding-risk-and-PPIs-v1.7.pdf

NICE 2020. NG185 Acute coronary syndromes https://www.nice.org.uk/guidance/ng185

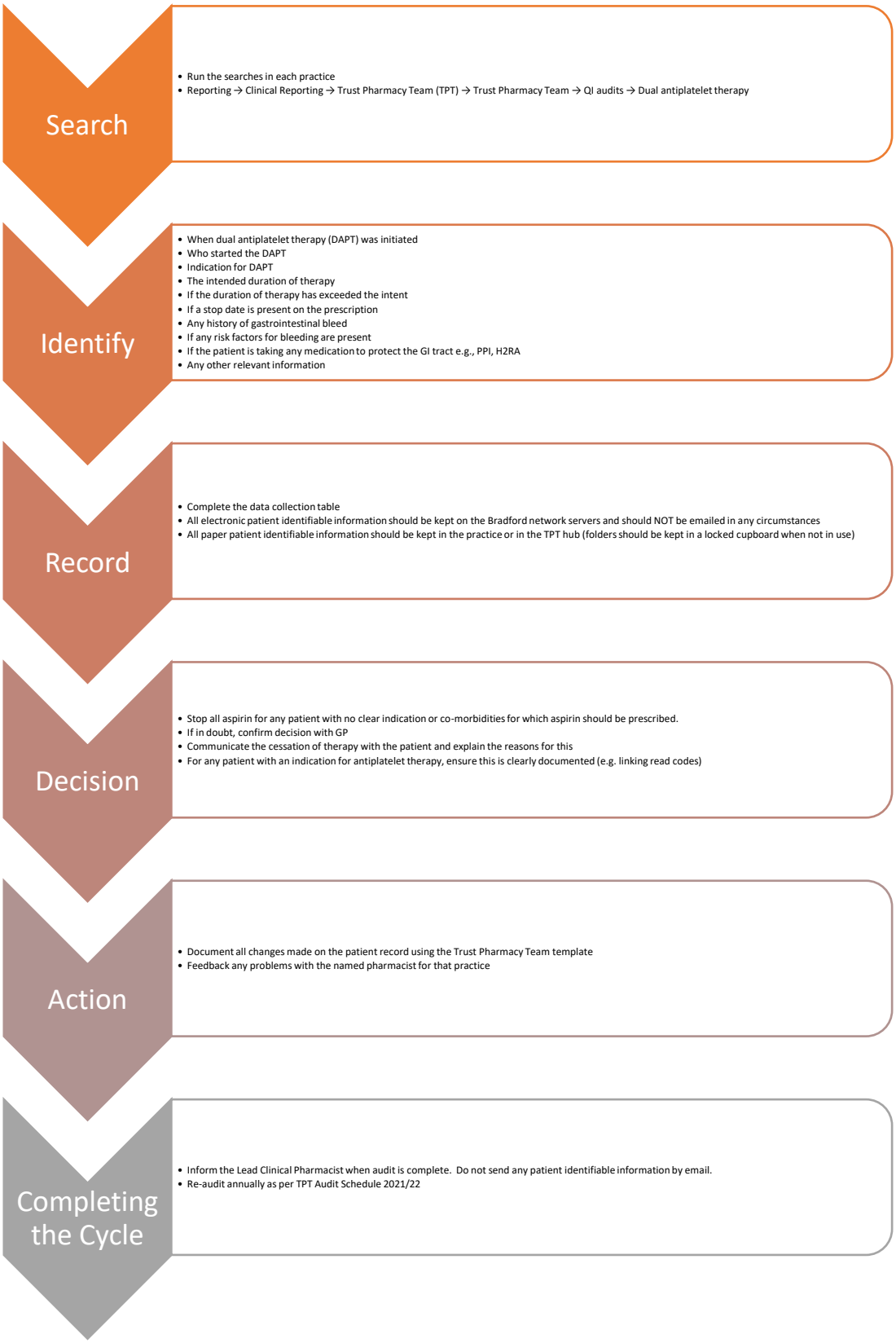
NICE 2020. Clinical Knowledge Summary; Antiplatelet treatment https://cks.nice.org.uk/topics/antiplatelet-treatment/

BNF Online 2021. https://bnf.nice.org.uk/

HAS-BLED https://www.mdcalc.com/has-bled-score-major-bleeding-risk

ORBIT https://www.mdcalc.com/orbit-bleeding-risk-score-atrial-fibrillation

If in any doubt at any stage, refer to a senior member of staff



Data Collection Form

Insert this information into Excel with an exported CSV from SystmOne

A	B	C	D	E	F	G	H
Patient Name	DOB	Age	Date DAPT started	Initiating specialty	Indication for DAPT	Intended duration of DAPT	Has the duration exceeded the intent? (Y/N)

I	J	K	L	M	N
Is there a stop date documented on the prescription?	Is there a history of GI bleed (If yes, when and what?)	Are there any risk factors for bleeding	GI protective medication?	Any other comments	Decision

Summary

Dual antiplatelet therapy

Practice .....

Pharmacy Technician .....

Named Pharmacist.....

Authorising GP .....

Date Audit Completed .....

Re-audit date .....

Information sent to CCG and LCP ☐

1	Number of patients identified for review ('Y's in column H)	
2	Number of patients requiring discontinuation of an antiplatelet	